



Last Updated: 03/09/2022

## **Interim Instructions for Waiver Providers in Use of API (Atypical Provider Identification) vs NPI (National Provider Identification) and Changes to KEPRO's Service Authorization Process and Impact on Provider Services — Effective July 1, 2015**

The purpose of this memo is to inform providers of upcoming changes to the service authorization processes performed by Keystone Peer Review Organization (KEPRO), the service authorization administrator for the Department of Medical Assistance Services (DMAS). This is the first of two memorandums informing providers of upcoming changes.

This memo is comprised of three (3) sections. Please review the bolded and numbered section headings to determine the upcoming changes.

### **1. EDCD Waiver Providers API vs NPI - what to do**

Beginning July 1, 2015, all providers who service Medicaid members who are enrolled in the Commonwealth Coordinated Care (CCC) will be required to use a National Provider Identifier (NPI) when submitting information to the Medicaid Managed Care Plans (MMPs). CCC MMPs will begin enforcing the requirement for an NPI on October 1, 2015. As of that date, claims submitted to a CCC MMP with an API will be rejected.

In the interim, Medicaid providers who currently have an Atypical Provider Identifier (API) should continue to use their APIs for billing existing fee for service authorizations. Providers should keep their fee for service authorizations under their API for now. This will keep the authorizations evenly dispersed throughout the calendar months.



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*Providers are NOT to submit requests to KEPRO to change **all** of their authorizations at the same time as this will cause a major backlog in processing the requests. KEPRO is not able to convert a large volume of authorizations to the new NPI at this time. This is **not an automatic** process and may take some time in processing the request.*

DMAS, Xerox, and KEPRO are currently working on a systematic approach to change mass volume service authorization requests. Providers who wish to use only their NPI will need to resubmit new authorization requests to KEPRO to change the current authorization to their NPI when this new systematic process is completed. The new systematic approach will allow a mass volume of service authorizations to be transferred from one provider identification number to another while keeping authorization renewal dates evenly dispersed. DMAS will send out a memo with further instructions for how this process will occur and alert providers when KEPRO is ready to

accept requests for the fee for service authorization transition. In the interim, providers should continue to use their API for existing fee for service authorizations under their API for successful claims submission.

## 2. EDCD Respite and Personal Care Providers: Process Change regarding aligning Personal Care and Respite - *Effective July 1, 2015*

KEPRO will no longer accept requests for aligning Personal Care and Respite authorizations effective July 1, 2015. Requests received on/after July 1, 2015 for the alignment of these services will not be processed, requests will be rejected and providers will receive a fax back notification. The EDCD Manual is currently being updated to include this change.

## 3. Procedural Change for Service Authorization Requests for Outpatient Rehabilitation Services -

***Effective Immediately***

This section notifies providers, specifically physicians and outpatient rehab professionals, of



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procedural changes in the service authorization process, for Outpatient Rehabilitation Services under the Fee-for-Service (FFS) Medicaid/FAMIS program related to service authorization requests submitted to KEPRO.

As stated in the DMAS Rehabilitation Manual, Appendix D, members have 5 units annually beginning July 1<sup>st</sup> that do not require service authorization for each service (OT, PT and SLP). "Annually" is defined as July 1 through June 30. If a provider knows that the member will need treatment beyond 5 units, the provider must request service authorization through KEPRO. These 5 units per rehabilitative discipline without service authorization are renewable each July 1. The 5 units are specific to the member only, not per provider.

Providers are to submit a service authorization request to KEPRO for dates of service that cover the entire duration of the member's current plan of care, even if the dates of service span over the state's fiscal year (beginning July 1). Providers are no longer required to submit an outpatient rehab service authorization request to KEPRO in which the dates of service end June 30 (end of state fiscal year) and then resubmit another service authorization request to KEPRO after the initial five units have been utilized in the next state fiscal year (July 1 and after).

### ***KEPRO's New Process:***

- Providers who obtain a service authorization approval for outpatient rehabilitative services from KEPRO with dates of service spanning the state's fiscal year (July 1), may utilize this service authorization number for claims submission for all dates of service included in the authorization.
- The provider must utilize the member's initial five units in the state fiscal year (beginning July 1 annually) that do not require service authorization.
- After the five units have been utilized, the provider continues to use the service authorization number given by KEPRO for all dates of service provided after the initial five units have been utilized through the last date of service approved on the service authorization.
- Providers are responsible to bill DMAS correctly for the first 5 units that do not require service authorization. Service authorization is required before payment will be made for any units over 5 annually. Providers may contact the Provider Helpline to determine if the first 5 units are available.

### ***Providers with Existing Service Authorizations (Srv Auths):***

*Current service authorizations ending on June 30, 2015 and when no other requests or authorizations have been submitted by a provider for a member:* If the plan of care spans July 1, 2015, the provider may submit a change request to KEPRO using the same Case ID or



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service authorization number for the units, dates of service, etc. included in the remainder of the plan of care. No additional review is required by KEPRO provided there has been no change to the existing plan of care including the frequency and duration. If there is a new physician order that changes the frequency and/or duration and would result in a new plan of care, then providers must submit a new service authorization request to KEPRO which would result in a new Case ID number and a new service authorization number in MMIS.

*Current service authorizations ending on June 30, 2015 and the provider has submitted a new request, received a new Case ID and/or service authorization number:* No change is needed. Provider utilizes the existing service authorization approved dates and units. When the approved dates of service have been utilized, the provider submits a new request to KEPRO as medically justified by a new physician order and/or new plan of care.

### ***DMAS Provider Training:***

DMAS will be providing a recorded training session which will review the outpatient rehabilitation process change contained in this memo. To access this training please visit the following link <https://dmas.webex.com/mw0401lsp13/mywebex/default.do?siteurl=dmas>. On the left hand menu select the drop down for "Attend a Session"; then click "Recorded Sessions." You will see a list of all recorded sessions. Select the title (Outpatient Rehab Service Authorization Changes & Billing Units That Don't Require Service Authorization). The Department will be following up with live Q&A sessions. All persons who accessed this recording will be notified of the dates and times of the Q&A sessions.

### ***KEPRO Provider Training:***

KEPRO will host four (4) webinar trainings to advise outpatient rehab providers of this new procedural change and demonstrate to providers how to utilize the Atrezzo Provider Portal in submitting an outpatient rehab initial request, change request and/or how to respond to a pend request for additional information. Listed below is the training link, conference call number, and dates and times for the outpatient rehab provider training:

<http://kepro.adobeconnect.com/r22u7ligcpd/>

To hear audio for the training, you must dial into the conference call using this telephone number and listening to the prompts: **866-754-2932, use code: 6815237722.**



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**Training Dates/Times for Outpatient Rehab providers:** Wednesday, June 10 at 2 p.m. and Thursday, June 18 at 2 p.m.; Tuesday, June 23 at 10 a.m.; and Tuesday, June 30 at 10 a.m.



## **COMMONWEALTH COORDINATED CARE**

Commonwealth Coordinated Care (CCC) is a new program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at [http://www.dmas.virginia.gov/Content\\_pgs/altc-enrl.aspx](http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx) to learn more.

## **MANAGED CARE ORGANIZATIONS**

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at [http://www.dmas.virginia.gov/Content\\_pgs/mc-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx).

## **VIRGINIA MEDICAID WEB PORTAL**

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov). If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at <http://dmas.kepro.com>.



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## **"HELPLINE"**

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-  
state long distance 1-800-552-8627 All other  
areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.